



9846 Hwy. 31 E. Tyler, TX 75705

Ph: 903-592-8001 • 1-877-696-8773

## Medical / Professional Referral

**Person Submitting Referral** \_\_\_\_\_

*(First and Last Name Please)*

**Facility** \_\_\_\_\_

**Contact** \_\_\_\_\_

**Phone** \_\_\_\_\_

**Fax** \_\_\_\_\_

**Patient** \_\_\_\_\_

M \_\_\_\_

F \_\_\_\_

DOB \_\_\_\_\_

**Patient's Complete Address** \_\_\_\_\_

Phone \_\_\_\_\_

SSN \_\_\_\_\_

Medicare # \_\_\_\_\_

Medicaid # \_\_\_\_\_

Please indicate patient's last MD visit date \_\_\_\_\_

or hospital discharge date: \_\_\_\_\_

Insurance Co. \_\_\_\_\_

Ins Co. Phone \_\_\_\_\_

Member Policy ID # \_\_\_\_\_

Group # \_\_\_\_\_

**Physician** \_\_\_\_\_

NPI # \_\_\_\_\_

TPI# \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

**Patient Primary Diagnosis** \_\_\_\_\_

**Secondary Diagnosis** \_\_\_\_\_

**Orders:**

Skilled Nursing

Home Health Aide

WOCN

Social Worker

Speech Therapy

Physical Therapy

Occupational Therapy

Other Orders/ Requested Frequency: \_\_\_\_\_

Requested SOC date: \_\_\_\_\_

Physician's signature \_\_\_\_\_

Date: \_\_\_\_\_

**Note: Please fax face sheet and H&P to fax number shown below.**

**Fax: 903-526-2329**

*Thank you for trusting us to care for your patient.*